STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345137	A. BUILDING _____ B. WING _____	C 08/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH VILLAGE	2221 WEST RALEIGH BOULEVARD ROCKY MOUNT, NC 27803

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F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to consistently provide 1 of 3 sampled residents (Resident #2) with pressure ulcers their supplemental bolus tubefeeding when meal intake was less than 50% as the resident transitioned between receiving nutrition by feeding tube and receiving nutrition by mouth. Findings included: 06/23/14 hospital lab results documented Resident #2's albumin level was low at 2.5 grams per deciliter (g/dL), with normal being 3.5 - 5.2 g/dL. Resident #2 was admitted to the facility on 06/25/14, and was discharged to the hospital on 08/12/14. The resident's documented diagnoses included nutrition via tube, dysphagia, diabetes, hypertension, and peptic ulcer disease. The resident's 07/02/14 Admission Minimum Data Set (MDS) documented her cognition was severely impaired, she was 5'7" and weighed 153 pounds, her weight was stable, she received	F 314	F 314 South Village Health and Rehab requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is 08/28/2014. Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with either the existence of, or scope and severity of any cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law. Resident #2 is discharged from the facility and no other corrective action can be completed for this resident. An audit has been completed by the Director of Nursing (DON)/and or designee on 08/22/14 of all residents currently identified as transitioning	8/28/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/28/2014

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F 314	Continued From page 1 greater than 51% of her calories from tubefeeding, and she was at risk for developing pressure ulcers, but she currently did not have any pressure ulcers. On 07/02/14 "Requires a PEG (percutaneous endoscopic gastrostomy) tube for adequate nutritional intake" was identified as a problem on the resident's care plan. A 07/09/14 physician order started Resident #2 on ProStat Max protein supplement 30 cubic centimeters (cc) x 60 days. A 07/10/14 physician order discontinued the resident's tubefeeding, and started the resident on puree foods and thin liquids by mouth, receiving MedPass 2.0 nutrition supplement 90 cc between meals. On 07/10/14 the resident's care plan was updated to document tubefeeding was discontinued. The weight record documented Resident #2 weighed 148.08 pounds on 07/15/14. A 07/15/14 Weekly Skin Check documented Resident #2 had excoriation to her sacrum and right buttock. A 07/15/14 physician order initiated the use of butt paste to the resident's sacrum and buttocks with peri-care. A 07/17/14 nurse's note documented the Standards of Care (SOC) committee discussed Resident #2's weight loss of 3.53% since admission. "Resident to be tube fed if she eats less than 50% of her meals."	F 314	between receiving nutrition by feeding tube and receiving nutrition by mouth for intake below 50% and whether an order has been transcribed for a bolus feed and if a bolus feeding was administered. No other resident was found to not have a nutritional recommendation carried out as ordered. The licensed nursing staff was in-serviced by the Director of Nursing and Assistant Director of Nursing on 08/22/14 regarding the need for supplemental bolus feeding while transitioning a resident between receiving nutrition by feeding tube and receiving nutrition by mouth as well as the importance of nursing assistants reporting to the licensed nurses percent of meal intake of less than 50% of nutrition by mouth. The percent of meal intake and receipt of bolus feeding is to be documented on the Medication Administration Record. Nurse Aides were in-serviced by the Director of Nursing and Assistant Director of Nursing on 08/22/14 to record the percent of meal intake of residents receiving nutrition by feeding tube as well by mouth on the resident tray card as a communication tool to the licensed nurses. All new hires will receive the in-services during orientation. The Director of Nursing and or designee will audit the Medication Administration Record two times weekly for three months	

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F 314	Continued From page 2 Record review revealed no corresponding physician order for supplemental bolus tubefeeding, and there was no documentation on the July 20014 medication administration record (MAR) of bolus tubefeeding when the resident ate less than 50% at meals. Intake for breakfast and lunch meals between 07/10/14 and 07/22/14 was not documented on the Meal Consumption Record. Intake for the supper meal between 07/10/14 and 07/22/14 averaged 35%, with intake below 50% documented four times. A 07/23/14 nurse's note documented "Will start restorative dining for cueing of meals." The weight record documented Resident #2 weighed 147.6 pounds on 07/28/14. On 07/28/14 the resident's care plan was updated. "Bolus as ordered if eats less than 50%." Intake for breakfast and lunch meals, eaten in restorative dining, between 07/23/14 and 07/31/14 averaged 29%, with intake below 50% documented seventeen times. Supper intake was not recorded on the Meal Consumption Record between 07/23/14 and 07/31/14. The weight record documented Resident #2 weighed 142.3 pounds on 08/08/14. A 08/08/14 nurse's note documented the resident was discussed during a SOC meeting since experiencing a weight loss of 11.2 pounds or 7.29% in one month. Initiation of an appetite	F 314	of all residents identified as transitioning between receiving nutrition by feeding tube and receiving nutrition by mouth for intake below 50% and whether an order has been transcribed for a bolus feed and if a bolus feeding was administered. The Director of Nursing will follow up with nursing assistants failing to report intake below 50% and licensed nurses failing to administer boluses appropriately as necessary. The Director of Nursing will present the results of those audits to the Quality Assurance Performance Improvement Committee monthly for review and recommendations for three months. All corrective action will be completed on or before 08/28/2014.	

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F 314	Continued From page 3 stimulant was recommended. Intake for breakfast and lunch meals, eaten in restorative dining, between 08/01/14 and 08/11/14 averaged 14%, with intake below 50% documented eighteen times. An electronic Meal Intake Report documented the resident's supper intake between 08/01/14 and 08/11/14 averaged 31% with intake below 50% documented six times. A 08/11/14 physician order started Resident #2 on one can of Glucerna 1.2 via feeding tube when meal intake was less than 50%. A 08/12/14 nurse's note documented Resident #2 was discharged to the hospital. At 11:20 AM on 08/21/14 the administrator stated before discharge to the hospital a nursing assistant (NA) found a pea-size open ulcer on Resident #2's sacrum. The NA reported she informed a nurse about the ulcer, but the nurse denied being told about the compromised skin integrity. According to the administrator, an action plan involving in-servicing and revision in the use of a Stop and Watch tool was implemented to prevent this lack of communication in the future. At 11:37 AM on 08/21/14 NA #1 (restorative NA) stated Resident #2 ate in restorative dining at the breakfast and lunch meals, and her average meal intake was 25%. She reported she informed the nurses about the meal intake, but she had not seen any nurse provide nourishment via feeding tube since the resident started the restorative program.	F 314		

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F 314	Continued From page 4	F 314		

At 11:45 AM on 08/21/14 NA #2, who cared for Resident #2 on first shift, stated the resident would not eat much of anything except for a little ice cream and pudding. She reported she had seen no bolus tubefeeding of the resident to supplement her poor intake by mouth until 08/11/14.

At 12:05 PM on 08/21/14 Nurse #1, Resident #2's primary care nurse on first shift, stated if the resident did not eat much she provided the resident with bolus tubefeeding. She reported this happened at about half of the resident's meals.

At 12:24 PM on 08/21/14, during a telephone interview, NA #3 (restorative NA) stated Resident #2 ate between 10% and 15% of her restorative meals. She reported if the resident's meal intake was below 50% the nurses were supposed to provide feeding through the resident's tube.

At 2:15 PM on 08/21/14, during a telephone interview, Nurse #2, who cared for Resident #2 on second shift, stated the resident was not eating well at all by mouth. However, she reported after the resident's nourishment via tube was discontinued the resident only received medications and flushes through this tube.

At 2:21 PM on 08/21/14 NA #4, who cared for Resident #2 on second and first shift, stated Resident #2 ate about 25 - 50% of her supper. She commented she reported meal intake to the nurse, but was not sure what the nurse did about poor intake by mouth.

At 3:06 PM on 08/21/14 Nurse #3, who cared for Resident #2 on second and first shift, stated on

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F 314	Continued From page 5 08/12/14 first shift NA #1 showed her a pressure ulcer to the resident's sacrum. She reported the NA told her it had already been reported to another nurse. Nurse #3 commented the pressure ulcer was the size of a dime, red, and presented as a stage II wound. According to Nurse #3, occasionally she would provide Resident #2's MedPass supplement via tube if the resident did not drink it well. She explained this supplement was ordered by mouth between meals to add to the resident's intake by mouth at meals. At 4:03 PM the director of nursing (DON) stated an order should have been written and the intervention should have been placed on the MAR after the 07/17/14 SOC recommendation was made to provide Resident #2 with bolus tubefeeding when her meal intake was below 50%. She explained this would ensure that staff on all shifts were aware of this new weight loss intervention. According to the DON, the SOC recommendation for an appetite stimulant was made on a Friday, 08/08/14. She explained that by Monday, 08/11/14, Resident #2 experienced a change in condition, and was not eating at all. Therefore, this intervention would not have helped the resident before she left for the hospital.	F 314		